General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lawthorn Pharmacy, 1 Cardow Crescent, Lawthorn Local Centre, IRVINE, Ayrshire, KA11 2DH

Pharmacy reference: 1041830

Type of pharmacy: Community

Date of inspection: 19/04/2022

Pharmacy context

This is a community pharmacy beside other shops in a local centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a medicines' delivery service. And it provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. The inspection was completed during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has safe and effective working practices. And it can show it manages its dispensing risks to keep services safe. The pharmacy keeps the records it needs to by law, and it suitably protects people's private information.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. Team members permitted a maximum of three people to enter the pharmacy at the one time. And the pharmacy provided hand sanitizer for people to use. A plastic screen at the medicines counter had been removed to carry out refurbishments. The pharmacy had not arranged for it to be re-installed, and team members knew to keep a safe distance from people. Most of the pharmacy team wore face masks throughout the day. And they also used hand sanitizer to protect each other from infections.

The pharmacy used documented working instructions to define the pharmacy's processes and procedures. And team members had recorded their signatures to show they had recently read and understood them. Sampling showed the responsible pharmacist had reviewed the procedures within the past two years. This included an ‘auditing of staff adherence to SOPs’ which they had introduced in February 2022. But it had not yet been implemented due to absences. Other procedures included the ‘assembly and dispensing’ which they had reviewed in March 2022 and the ‘dealing with near-misses and errors’ procedures in July 2020. Pharmacy team members signed medicine labels to show who had ‘dispensed’ and who had ‘checked’ prescriptions. This meant the pharmacist and the ‘accuracy checking technician’ (ACT) were able to identify dispensers to help them learn from their dispensing mistakes. Even though a 'near miss' procedure was in place, team members had only recorded one error in 2022. This was not reflective of the actual number of near misses that had occurred. Team members were able to demonstrate awareness of ‘look alike and sound alike’ medicines and packs. This included estradiol cream 0.1%/0.01% and sildenafil/sertraline and they knew to take extra care when selecting those products. The pharmacy employed an ‘accuracy checking technician’ (ACT). The ACT followed the pharmacy’s accuracy checking procedure. This included only checking prescriptions that had been annotated by a pharmacist. The ACT checked a significant number of multi-compartment compliance packs. Dispensing of the packs was carried out by experienced dispensers. They followed the pharmacy’s procedure for the assembly of packs which was valid until February 2023. This included checking prescriptions against supplementary records which helped to reduce the risk of dispensing errors.

The pharmacy did not display a notice or provide information to help people complain if they needed to. But it had defined the process in a documented procedure which was valid until February 2023. Team members had evidenced they had read the procedure and knew how to effectively handle complaints. The pharmacist recorded dispensing incidents on an electronic form. The form included a section to record information about the root cause and the mitigations to improve patient safety. Sampling showed no incident records. And the responsible pharmacist confirmed there had been no incidents over the past few years.

The pharmacy maintained the records it needed to by law. It had public liability and professional indemnity insurances in place which were valid until 31 August 2022. The pharmacist displayed a responsible pharmacist notice, and it was visible from the waiting area. The RP record was up to date and showed which pharmacist had been on duty when the pharmacy was operating. Team members maintained the electronic controlled drug registers and kept them up to date. They had last evidenced they had checked and verified the stock balances on 15 November 2021. People returned controlled drugs they no longer needed for safe disposal. A destructions book showed the pharmacist had signed the records to confirm that destructions had taken place. Team members filed prescriptions so they could be easily retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials' were up to date. The pharmacy did not display a notice to inform people about how it used and processed their personal information. Team members knew how to protect people's confidential information. For example, they knew to use a shredder to dispose of confidential waste. And they knew to keep personal information out of sight of people in the waiting area. Team members knew to discuss safeguarding concerns with the pharmacist. This included concerns about failed deliveries or collections of multi-compartment compliance packs. They knew how to access contact details for key agencies in the event they needed to make a referral. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. This also helped to protect children and vulnerable adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They are proactive at learning and making improvements in the workplace. And they complete training to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's workload had increased significantly since a change of ownership in 2020. This was due to different factors including the installation of a prescription collection point. The new owner had increased the number of team members. And they had extended the dispensary into the waiting area. This had increased the number or workstations to provide more space for the new team members. The superintendent pharmacist visited the pharmacy on a regular basis. This was to support the pharmacist and the pharmacy team. It was also to provide cover due to difficulties recruiting locum pharmacists. The pharmacy team was well-established, and individuals were experienced and competent in their roles and responsibilities. The 'medicines counter assistant' (MCA) knew to monitor sales of codeine containing products. And they provided advice so that people knew they were for short term use only.

The team included one full-time pharmacist, one part-time accuracy checking technician, two full-time dispensers, one part-time dispenser, one part-time trainee dispenser, two part-time medicines counter assistants and one part-time delivery driver. The pharmacist had not been able to allocate protected learning time to support the trainee dispenser due to absences. Stability within the team had recently improved and was providing the opportunity to implement all the pharmacy's processes. For example, the medicines counter assistant had recently completed a full date-check of medicines counter stock.

The pharmacist supported team members to learn. And kept them up to date with new services and changes to established services. This included changes to the list of products available via the NHS pharmacy first service. And when the company introduced a new flu vaccination service, the pharmacist had briefed the pharmacy team. This ensured they were able to gather the relevant information from people before they were vaccinated by the pharmacist. The pharmacist had enrolled on the 'pharmacist independent prescribing' (PIP) course. And a local GP had agreed to take on the mentoring role that was a course requirement. The pharmacist had been reflecting on the needs of the local population. And they were considering prescribing to provide improved access to contraception.

The pharmacy team had been proactive at identifying areas for improvement. Not long after the introduction of the collection point a dispenser had suggested using coloured baskets for different prescriptions. This included using a yellow basket to show prescriptions for the collection point. And blue baskets for prescriptions for delivery.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises adequately support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

Team members had arranged the dispensing benches for different tasks. And they had segregated workstations to help maintain a safe distance from each. The pharmacist and the ‘accuracy checking technician’ (ACT), each had a separate checking bench. And a dispenser used another bench for dispensing multi-compartment compliance packs. The dispensing benches were clutter free. And dispensing baskets kept prescription items well-contained. Team members used a series of dedicated shelves for storing multi-compartment compliance packs. And they kept them tidy with packs well-segregated. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary. A sound-proofed consultation room was available. And it provided a confidential environment for private conversations. Team members used a separate counter to provide substance misuse services. And the ‘medicines counter assistant’ (MCA) cleaned the surfaces in the consultation room and at the counter in between sessions.

A sink in the dispensary was available for hand washing and the preparation of medicines. The pharmacy was clean and well maintained. Team members cleaned and sanitised the pharmacy on a regular basis. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services. A separate area was used for comfort breaks. This allowed team members to remove their face masks without being at risk of infections.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy gets its medicines from reputable sources and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are not fit for purpose. The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care.

Inspector's evidence

The pharmacy had a step-free entrance and provided unrestricted access for people with mobility difficulties. It advertised its services and opening hours in the window. And it provided information to help keep people safe from coronavirus, such as information about long Covid. A Facebook page also kept people up to date with service changes. The pharmacist provided access to 'prescription only medicines' via 'patient group directions' (PGDs). They kept 'hard copies' of the PGDs in folders that were easy to access. And sampling showed the PGD for flucloxacillin was valid until May 2023. The pharmacist provided treatments using the 'community pharmacy urgent supply' (CPUS) PGD. And they sent hard copies of each prescription to the person's GP.

Team members kept stock neat and tidy on a series of shelves. And they used controlled drug cabinets that had adequate space to safely segregate stock items. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members had recently re-introduced documented expiry date checks. Sampling showed that items were within their expiry date. The pharmacy used a fridge to store items at the recommended temperature. It was organised, and team members monitored and documented the temperatures daily. They were able to evidence it had been operating within the accepted range of 2 and 8 degrees Celsius. Team members knew about valproate medication and the Pregnancy Prevention Programme. And a procedure was available for them to refer to. The pharmacist knew to speak to people in the at-risk group about the associated risks. And team members knew to supply patient information leaflets and to provide warning information cards with every supply.

The pharmacy supplied medicines in multi-compartment compliance packs to a significant number of people. This had increased since the change of ownership in 2020. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. The procedure was up to date and was valid until February 2023. A long serving dispenser was responsible for carrying out all the associated tasks including the assembly and labelling of the packs. Another dispenser had been trained to provide cover when the lead dispenser was absent. Team members used trackers to manage the dispensing process. This helped them to order new prescriptions and ensure they had sufficient time to process subsequent supplies. Supplementary records which contained a list of the person's current medication and dose times were kept up to date. Team members checked prescriptions against the master records for accuracy before they started dispensing packs.

The pharmacy dispensed serial prescriptions for people that had registered with the 'medicines care review' service (MCR). Team members had attached trackers to each prescription and dispensed them in advance. This ensured they were ready by the due date. It also helped them manage their workload.

Sampling showed that people collected their medication on the date it was due. The pharmacy had started providing substance misuse services since it had last been inspected on 2 October 2018. Team members dispensed doses a week in advance. And the pharmacist checked the doses at the time of dispensing and again at the time of supply.

The pharmacy used a collection point so people could collect their prescriptions at their convenience, including when the pharmacy was closed. The pharmacy had carried out a risk assessment and had excluded high risk medications such as controlled drugs. Team members placed fridge items inside only if they were confident of collection. And they checked the machine the following day to confirm they had been collected. The pharmacist annotated prescriptions when they wished to speak to people about their medications. This meant that dispensers excluded prescriptions and kept them to the side. They informed people to speak to the pharmacist when they messaged them that their prescription was ready for collection. Team members used yellow baskets for prescriptions that were for the collection point. And they removed prescriptions that had not been collected within three days. The supplier of the collection point had recently carried out a system update. And team members only needed to scan the bar-code on each of the prescriptions once instead of twice before placing them inside the collection point. This ensured prescription were placed in the collection point in a timely manner. Team members had responded when people complained they could not read the screen when the sun was shining. They had contacted the system provider who installed a fan to stabilise the temperature and maintain visibility of the screen.

The delivery driver kept a supply of face masks, gloves, and hand sanitizer in the delivery vehicle, and they used them during deliveries. They knew to keep at a safe distance from people to manage the risk of spreading infection. Team members accepted unwanted medicines from people for disposal. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Drug alerts were prioritised, and team members knew to check for affected stock so that it could be removed and quarantined straight away. Sampling showed that team members acted on alerts, such as checking for Boots Decongestant in March 2022.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy used a collection point. And the company that provided it was on hand to carry out repairs and support the pharmacy team when there were problems. The pharmacist believed a service contract was in place. But they could not remember the frequency of the services. The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used a separate measure for methadone. The pharmacy stored prescriptions for collection out of view of the waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. A portable phone allowed team members to carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.